



DENTAL APPLICATION AND CHANGE FORM

PLEASE COMPLETE AREAS BELOW – PLEASE PRINT

1. LAST NAME	FIRST NAME	INT.	DATE OF BIRTH	SEX	SOCIAL SECURITY NO.	OFFICE USE ONLY															
APPLICANT			MO. DAY YEAR			I.D.No.															
ADDRESS OF APPLICANT (Street)			(City)	(State)	(ZIP)	Group No.															
2. CURRENT EMPLOYMENT INFORMATION				GROUP#	MARITAL STATUS		Effective Date														
EMPLOYER'S NAME					<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">PLN.</td> <td style="width: 10%;">PKG.</td> <td style="width: 10%;">CH</td> <td style="width: 10%;">RSN</td> <td style="width: 10%;">WWP</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>					PLN.	PKG.	CH	RSN	WWP					
PLN.	PKG.	CH	RSN	WWP																	
DATE OF HIRE	DEPT.	CLOCK NO.	OCCUPATION	3. BENEFIT SELECTION		Comment															
				<input type="checkbox"/> Individual	<input type="checkbox"/> Employee/Spouse																
				<input type="checkbox"/> Family – list mbrs below	<input type="checkbox"/> Employee/Child(ren)																

4. CURRENT INSURANCE INFORMATION	OTHER INSURANCE INFORMATION
Arkansas Blue Cross Dental Policy #: _____ Arkansas Blue Cross Health Policy #: _____ Health Advantage Health Member #: _____	Do you or any member of your family covered under this application have other dental insurance with another insurance company? <input type="checkbox"/> NO <input type="checkbox"/> YES – List Name of company and policy number _____

5. CHANGE COVERAGE AS INDICATED BELOW	
<input type="checkbox"/> CHANGE TO INDIVIDUAL DUE TO: <input type="checkbox"/> Death – Date: _____ <input type="checkbox"/> Divorce – Date: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> CHANGE MY NAME TO (AS SHOWN ABOVE) FROM: _____	<input type="checkbox"/> CHANGE TO FAMILY DUE TO: <input type="checkbox"/> Marriage – Date: _____ <input type="checkbox"/> Other – Explain: _____ (If dependents are to be covered, list in Section 6)

6. CHANGE IN DEPENDENT STATUS										
Add	Delete	LAST NAME	FIRST NAME	M. INIT.	Birthdate	Relationship	Sex	SSN	Date of Change	Reason (for deletion only)
<input type="checkbox"/>	<input type="checkbox"/>									
<input type="checkbox"/>	<input type="checkbox"/>									
<input type="checkbox"/>	<input type="checkbox"/>									
<input type="checkbox"/>	<input type="checkbox"/>									
<input type="checkbox"/>	<input type="checkbox"/>									
<input type="checkbox"/>	<input type="checkbox"/>									

AUTHORIZATION & SIGNATURE		
<p>I understand that no benefits for services of any kind are provided for treatment that was received prior to the effective date of my dental coverage.</p> <p>I do hereby authorize any dentist, hospital or other provider of medical services or supplies to make available to Arkansas Blue Cross and Blue Shield upon request any and all medical records and facts pertaining to us and our physical condition.</p> <p>Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p>		
_____ Print Name of Applicant	_____ Signature of Applicant	_____ Date
_____ Print Employer/Group Representative	_____ Signature Employer/Group Representative	_____ Date